Volume 3 Issue 2

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Arizona Medical Board and Arizona Regulatory Board of Physician Assistants

Inside this issue:

Letter from the Chair, William R. Martin III, M.D.

A few weeks ago, I had the privilege to discuss possible changes in our healthcare system with a group of medical students. Although I was one of the main speakers that night—it was I who took home a number of different learning points. Perhaps first and foremost was the genuine encouragement that I found in the medical students by their in depth questions and insights. It became clear to me that the medical students of today, seemingly, have evolved in many different ways. The questions that I received that night were more about healthcare policy and healthcare economics than what I remember asking more than fifteen years ago. There were questions regarding very specific policy platforms of our President-Elect, Barack Obama. I truly felt, in spite of our different levels of achievement in the field of medicine, that the core values that have drawn all of us to medicine remain intact. These core values include an intense and keen desire to serve others.

Many of the questions that night dealt with what the healthcare focus of the Obama Administration may be. Barack Obama's website points out three proposed pillars to aid in healthcare reform.

- Lower costs to make the health care system work for people and businesses.
- Provide affordable and accessible healthcare coverage options for all.
- Promoting prevention and strengthening public health.

It is this third pillar on which I would like to focus. These young physicians and surgeons in-training made it clear that they want to "roll up their

(Continued on page 2)

Letter from the ARBoPA Chair, by Joan Reynolds, M.M.S., P.A.-C

What is a Supervising Physician? What does supervision mean? What is an NOS form?

Every practicing physician assistant should know the answers to these questions, but I am sorry to say that we on the Arizona Regulatory Board of Physician Assistants find this just isn't so. Without fail, we have had cases at each meeting involving a PA who was found to be practicing without proper supervision.

After hearing a number of cases, it is apparent to me that people tend to get a bit lax and complacent in their practices and forget the importance of their supervising physicians and their role in providing quality care.

"NOS" does not mean "not otherwise specified," but Notice of Supervision. You and your supervising physician completed the NOS form enabling you to perform the healthcare tasks the physician assigned to you. Your responsibility is to make sure you and your supervising physician follow the Statutes, Rules and our new PA Supervision Guidelines.

Dr. Eugene Stead founded this profession on the notion that physician assistants receive excellent training, are licensed to practice, and are to be mentored/supervised by a physician to ensure quality and access to healthcare. The American Academy of Physician Assistants supports our continued healthcare team approach with supervision. There is no mistake that we stand for a TEAM approach for delivery of healthcare and embrace our supervising physician colleagues.

So why do we continue to see our physician assistant colleagues come before the PA Board having performed duties which their supervising physicians knew nothing about? Their usual response is, "I didn't know" or "I assumed that my office submitted my forms," or worse, a PA did know and understood but just practiced

(Continued on page 3)

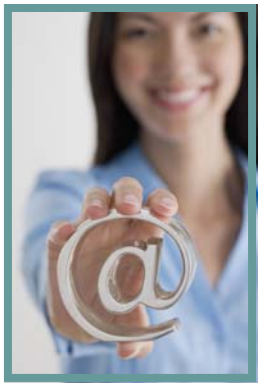
This article reflects the views of the author. Unless noted, it does not necessarily reflect the view of the Arizona Regulatory Board of Physician Assistants or any other member of the Arizona Regulatory Board of Physician Assistants

Letter from the Chair, continued

(Continued from page 1)

sleeves" and work hard to make this world a better place. I dare say that this is the desire of all of us. The question is, with all of the financial woes that our State and our Nation are currently enduring, how can WE be pro-active in promoting healthcare prevention and strengthening our public health system?

"As it stands, only four cents of every healthcare dollar is spent on prevention."



One of the many things that the recent Presidential campaign has taught our nation is that amazing things can happen if we appropriately harness the power of the internet. This sentiment is echoed in our own homes through our children and was displayed to me through these medical students. These younger Americans seem to be more computer savvy than when you and I were growing up. This makes sense in that when I was in school I used to have to write and type my essays on "onion skin" paper to help with my corrections. Now, I would not think of writing a paper without using a word processor. "E-mails" and "blogs," if used appropriately, can serve as conduits of information from allopathic physicians to our patients. Further, they can be readily employed for little to no additional costs.

Can we envision our practices using emails and blogs for preventative medicine in a pro-active manner? Is it possible for the orthopedic surgeon or the physiatrist to send e-mail reminders to their low back pain patient's about the importance of abdominal muscle strengthening exercises and the need to lift heavy loads primarily with their knees as opposed to their backs? Is it possible for the pathologist or the oncologist to send a reminder to the patient who has previously been diagnosed with basal cell carcinoma to check his/her skin for additional lesions on a regular and periodic basis? Is it possible for the internist or the family medicine physician to send an e-mail reminder in the springtime to their patients with asthma warning them that pollen counts are increasing and therefore special precautions ought to be taken to limit their exposure? Is a possible for the general surgeon or the gastroenterologist to send a yearly reminder to their older patients regarding the need for a colonoscopy? Can the pediatrician send out guided notes to patient's families reminding them of the need for specific immunizations? Can we set up blogs and email chains so that patients can share their common experiences regarding nutrition and exercise and then WE as their physician monitor the sites and add relevant and pertinent data to stimulate discussion and learning? Clearly, the examples are endless.

I am certain that as you are reading this, you are perhaps saying that this may be a good idea, but, I do not have enough time as it is. How can I add more to my plate of never ending tasks and duties as an allopathic physician? There are no easy answers. As it stands, only four cents of every healthcare dollar is spent on prevention. Our nation is facing "a true epidemic of chronic disease." Americans are suffering and dying needlessly from diseases such as obesity, diabetes, heart disease, asthma and HIV/AIDS. We know that public health policies and preventative healthcare measures can delay the onset of these diseases or entirely prevent them.

Heart disease, cancer, stroke, COPD, and diabetes cause over two-thirds of all deaths each year. Costs associated with diabetes are more than $130 billion each year. Although it will not happen overnight, just imagine the human toll and suffering that would be reduced and the monies that could be saved if we were able to be PROACTIVE in our approach to these chronic diseases as opposed to our current reactionary ways.

Seemingly, there are always more questions than answers. There will be challenges. What about the patients and families that do not have access to the internet? Who will pay for the software in our offices to employ these preventative measures? Will our malpractice carriers agree to let us more freely utilize the internet in these new and innovative ways? In spite of all this, however, we must continue to ask questions and seek answers that will allow us to join hands and fight together to better provide preventative healthcare for our patients. Let US be in the avant guard in leading the way to bring forth new and innovative ways to merge our talents and skills as allopathic physicians with emerging information technologies.

Dr. Martin is the Chair of the Arizona Medical Board and has an orthopaedic surgery practice in Phoenix.

This article reflects the views of the author.

Unless noted, it does not necessarily reflect the view of the Arizona Medical Board or any other member of the Arizona Medical Board.

Making the Call: When to Report a Health Care Professional, by Lisa Wynn

All licensed healthcare professionals in Arizona share a common obligation: they have a duty to report other health professionals for unsafe or unprofessional conduct to the appropriate regulatory agencies. The goal is to protect the public from harm.

Arizona law also requires hospital officials and their staffs to report a physician to the Arizona Medical Board when they suspect he or she may have committed unprofessional conduct. Until recently, however, the question of when that report should be made to the Medical Board was unclear in the community. This confusion resulted in delayed reports to the Board, often after a hospital's review committee had completed its investigation and disciplined a physician.

According to A.R.S. § 32-1451(A), any health care institution shall report to the Board "any information that appears to show that a doctor of medicine is or may be medically incompetent, is or may be guilty of unprofessional conduct, or is or may be mentally or physically unable safely to engage in the practice of medicine." A.R.S. § 32-1451(B) states that the chief executive officer, the medical director and the chief of staff of a health care institution have a duty to report to the Board when it denies, revokes, suspends or limits privileges of a doctor to practice there.

Noting the opportunity for confusion regarding the Duty to Report, the Arizona Medical Board assigned the task of developing a Substantive Policy Statement to a Board Subcommittee, chaired by Tucson Board Member Robert Goldfarb, M.D., FACS. The aim was to produce a consistent and clear approach to the statutory provisions that would take away much of the guesswork about what triggers the duty to report and who must report it. After several months of work, and with input and assistance from the Arizona Hospital Association, the subcommittee presented its proposed Substantive Policy Statement #13 to the full Board during its regular meeting on June 5, 2008, and the Board unanimously adopted it. The official title is "Duties of Hospitals and Physicians to Report Peer Review/Quality Assurance Information."

The Policy clarifies that a report must be made whenever a facility terminates, limits or suspends a physician's hospital privileges, even if all due process has not been exhausted. The Policy indicates that the report may be made "following a brief assessment" and based on information "that appears to be credible." It also indicates that duplicative reports from different individuals describing the same information are not required, as long as one report is made. It is the facility's Medical Director who will be responsible to the Medical Board to ensure that a report is made.

For a full copy of the Substantive Policy Statement please go to the Arizona Medical Board's Website at http://www.azmd.gov/Regulatory/policy/SPS13.pdf

"...a report must be made whenever a facility terminates, limits or suspends a physician's hospital privileges."

Lisa Wynn became Executive Director of the Arizona Medical Board in January 2008. Previously, she was Deputy Assistant Director of the Division of Licensing for the Arizona Department of Health Services.

Letter from the ARBoPA Chair (continued)

(Continued from page 1)

without supervision anyway. (Fortunately, the latter happens infrequently.) The responsibility falls to the Physician Assistant and Supervising Physician to understand and implement the PA's scope of practice.

I believe education is the best tool in helping PAs understand the law and how it applies to you and your practice in Arizona. I know the Arizona State Association of Physician Assistants (ASAPA) has had open forum workshops referencing these issues at the spring conferences held in Sedona.

The staff at the PA Board can answer general questions and direct you to the appropriate statute or rule, but they cannot provide you with legal advice.

During the last session of the State Legislature, lawmakers amended the law, allowing the Arizona Medical Board to quiz new applicants and those renewing their licenses about the Medical Practice Act as part of the online renewal and initial licensure process for MDs. They won't be required to pass the quiz, just complete it as an educational tool. The Medical Board hopes to implement that soon.

I've heard discussion about testing physician assistants on their knowledge of state law before they are granted a license or a renewal. This would be a great opportunity for PAs to understand the law and improve their practices.

The large group practice where I work already requires all supervising physicians to take a 10-minute online exam regarding supervision of PAs and the statutes. This is one step in the right direction of ensuring compliance with state law and quality health care.

Joan Reynolds. P.A.-C is Chair of the Arizona Regulatory Board of Physician Assistants. She is a practicing PA at Mayo Clinic in Scottsdale.

Frequently Asked Questions, by Roger Downey

Each day, the Arizona Medical Board and the Arizona Regulatory Board of Physician Assistants will receive some 10 to 20 questions at the general email address, questions@azmd.gov.

Frequently, the questions pertain to licensure eligibility for physicians who have attended a school outside the country. Foreign medical school graduates have sent lengthy emails with impressive curriculum vitae and ask about their chances for obtaining an Arizona medical license. The answer depends on what they have done regarding statutory requirements for a license, not on their extensive experience in their home countries. The State Legislature has decided that licensure requirements for IMGs - international medical graduates - should be stricter because of the difficulty of assessing education standards and competency.

"...an applicant must be able to read, write, speak understand and be understood in the English language."

The issue is not limited to non-citizens of the United States. Many America students, who find it difficult to gain admittance to a medical school in the U.S., pursue a medical degree in a foreign country. But unless they've been successful in getting into post-graduate programs approved by the Accreditation Council for Graduate Medical Education (ACGME), their attempts to be licensed and practice medicine in this country may fall short.

For Arizona, the only "approved" allopathic medical schools are those with accreditation from the Liaison Committee on Medical Education in the United States and Canada. All others are in the "unapproved" category. The Arizona Revised Statutes address the licensure requirements for students from "unapproved" schools of medicine. A.R.S. § 32-1423 states that an applicant must be able to read, write, speak, understand and be understood in the English language. An IMG must hold a standard certificate from the Educational Council for Foreign Medical Graduates, complete a fifth pathway program, or complete 36 months as a fulltime assistant professor at an approved school of medicine. Plus, the foreign medical school graduate must successfully complete a 24-month hospital

internship, residency or clinical fellowship program in addition to the 12-months required for students who went to an "approved" school of medicine.

Most of the email queries that the Board receives from doctors outside the United States indicate they have taken and passed Steps 1, 2, and 3 of the USMLE. But if they have not completed a 36-month post-graduate residency, internship or fellowship at an ACGME institution, they are ineligible to apply for an Arizona license.

PAs have questions too

The general email address receives fewer queries overall from physician assistants, but the bulk of them tend to come in during the month preceding their annual licensure June First. As graduation approaches, most are lining up employment opportunities. They're anxious to start their careers and begin earning money, so many of their questions relate to the timing of their licenses' arrival in the mail or to the certification requirement for initial licensure.

A physician assistant's license is only part of what is necessary for a PA to practice in Arizona. The statutes require that every physician assistant must have written approval from the PA Board of his or her Board-approved supervising physician in order to perform health care tasks. A.R.S. § 32-2531 says that "after a supervising physician receives board approval of a notice of supervision, that physician may delegate health care tasks to the physician assistant."

The PA Board's rules are quite specific about eligibility for licensure. R4-17-202 states that a graduate from an approved school "who presents a certificate issued by NCCPA (National Commission on Certification of Physician Assistants) that shows the applicant passed the PANCE (Physician Assistant National Certifying Examination) or the NCCPA recertification examination within the six-year period preceding presentation of the certificate to the Board shall be deemed to have met the requirement [of the statutes]."

If you have a question for the Arizona Medical Board or the Arizona Regulatory Board of Physician Assistants, send it to:

questions@azmd.gov.

Roger Downey responds to the email the Arizona Medical Board and the Arizona Regulatory Board of Physician Assistants receives. He is the Boards' Media Relations Officer.

Number of Licensed Physicians:

19,911

Number of Licensed PAs

1,760

State Pharmacy Board's New Monitoring Program, by Dean Wright

Arizona's Forty-Eighth Legislature passed H.B. 2136 establishing a Controlled Substances Prescription Monitoring Program (CSPMP). The bill requires the Arizona State Board of Pharmacy (ASBP) to establish a controlled substances prescription monitoring program and requires pharmacies and medical practitioners who dispense controlled substances listed in Schedule II, III, and IV to a patient, to report prescription information to the Board of Pharmacy on a weekly basis. The new statutes, A.R.S. Title 36, Chapter 28 are available on the Board's website under the "CS-Rx Monitoring Program" link. Go to: www.azpharmacy.gov.

Arizona is not the first state to have a prescription monitoring program. Far from it, Arizona is one of 38 states that have legislation establishing a monitoring program. Arizona is surrounded by five states (California, Nevada, Utah, Colorado, and New Mexico) with operational CSPMPs. There are a total of 28 states with operational CSPMPs. There are ten states, including Arizona, that have enacted CSPMP legislation, but the programs are not yet operational. There are six states who are attempting to pass CSPMP legislation.

A 2005 survey by the federal Substance Abuse and Mental Health Services Administration (SAMHSA) shows that 17% of substance abusers obtained drugs by presenting pain complaints to multiple physicians. Substance abusers often seek prescriptions from more than one doctor. By filling the prescriptions at different pharmacies, they are often able to avoid notice.

A.R.S. § 36-2602 of House Bill 2136 requires the ASBP to establish a controlled substances prescription monitoring program that:

Includes a computerized central database tracking system to track the prescribing, dispensing and consumption of Schedule II, III, and IV controlled substances in Arizona

- Assists law enforcement in identifying illegal activity related to the prescribing, dispensing and consumption of Schedule II, III, and IV controlled substances,
- Provides information to patients, medical practitioners, and pharmacists to help avoid the inappropriate use of Schedule II, III, and IV controlled substances, and
- Is designed to minimize inconvenience to patients, prescribing medical practitioners and pharmacies while effectuating the collection and storage of information.

The purpose of this legislation is to improve the State's ability to identify controlled substance abusers or misusers and refer them for treatment, and to identify and stop diversion of prescription controlled substance drugs in an efficient and cost effective manner that will not impede the appropriate medical utilization of licit controlled substances.

The primary function of the ASBP is to provide a central repository of all prescriptions dispensed for Schedule II, III, and IV controlled substances in Arizona. Authorized persons may request information from this repository to assist them in treating patients and identifying and deterring drug diversion, consistent with A.R.S. § 36-2604. Assuring confidentiality and the security of the data is a primary consideration for this program for all aspects to include data collection and storage, transmission of requests, and dissemination of reports.

A.R.S. § 36-2603 requires the Board to appoint a Computerized Central Database Tracking System Task Force. The Task Force's purpose is to establish the procedures and conditions relating to the release of prescription information from the database. Specifically, the Task Force will determine illegal or unprofessional conduct to be screened, set thresholds and frequency of the screening, and set parameters for using the prescription information in the database.

The Task Force has yet to establish the threshold of doctors and pharmacies a patient would have to see in, for example a month's time, in order to generate a report. The Task Force members appear to be leaning toward five doctors and five pharmacies, which mirrors the Nevada prescription monitoring program. Once a patient has seen five different doctors and filled prescriptions at five different pharmacies within a one month period, the CSPMP would send a report to each physician who wrote a prescription for that patient for evaluation.

So, where is the Board in implementing the program? The Board awarded a contract to Health Information Designs of Auburn, Alabama on March 31, 2008 to provide data collection, database storage and management, and web hosting services. The Board will begin collecting data from pharmacies in October 2008. The Board will begin collecting dispensing practitioner's data in October 2009.

Once the prescription monitoring program is operating, the Board will provide medical practitioners with instructions on how to access the database. If you have any questions, contact Dean Wright, Prescription Monitoring Program Director at (602) 771-2744 or by email at dwright@azpharmacy.gov.

Dean Wright, RPh, is the Prescription Monitoring Program Director for the Arizona State Board of Pharmacy.

"Substance abusers often seek prescriptions from more than one doctor."

Recent MB and ARBoPA Actions and Orders

The Arizona Medical Board and the Arizona Regulatory Board of Physician Assistants have legal authority to revoke, suspend, restrict, fine, reprimand or censure, require monitoring or additional education, or impose other remedial measures on the license of an allopathic physician (M.D.) or physician assistant if the licensee has committed unprofessional conduct or is mentally or physically unable to safely engage in the practice of medicine.

The Medical Board, at its discretion, may issue a non-disciplinary order for additional CME courses.

The Boards have recently taken the following actions:

AMB

Patricia L. Clarke, M.D.

(Flagstaff—Diabetes/Family Practice)

Arizona License No. 26877

Accepted Consent Agreement for Decree of Censure and 5 years Probation.

Stephen E. Flynn, M.D.

(Phoenix—General Surgery)

Arizona License No. 3351

Accepted Consent Agreement for Surrender of License.

Ole G. Torjusen, M.D.

(Norway—OB-GYN)

Arizona License No. 19487

Accepted Consent Agreement for Surrender of License.

Scott A. Wasserman, M.D.

(Scottsdale—Internal Medicine)

Arizona License No. 23328

Ordered Decree of Censure and 5 years Probation with random chart reviews.

Stephen G. Glacy, M.D.

(Scottsdale—Anesthesiology)

Arizona License No. 17082

Accepted Consent Agreement for Surrender of License.

Gustave A. Matson, M.D.

(OB-GYN)

Arizona License No. 15992

Accepted Consent Agreement for Decree of Censure and 5 years Probation with quarterly chart reviews.

Lynn M. Keating, M.D.

(Emergency Medicine)

Arizona License No. 19688

Accepted Consent Agreement for Letter of Reprimand and Practice Restriction for 10 years. Shall not practice clinical medicine involving patient care and is prohibited from prescribing any form of treatment.

Jeffrey C. McManus, M.D.

(Ojai, CA—Internal Medicine)

Arizona License No. 35573

Accepted Consent Agreement for Letter of Reprimand with 5 years Probation.

James W. Schouten, M.D.

(Payson—Internal Medicine)

Arizona License No. 26278

Accepted Order for Letter of Reprimand and Practice Restriction.

Cayetano S. Munoz, M.D.

(Phoenix—Anesthesiology)

Arizona License No. 9506

Accepted Consent Agreement for Surrender of License.

Humberto Rosado, M.D.

(Yuma—Family Medicine)

Arizona License No. 19978

Accepted Consent Agreement for a Stayed Revocation, Practice Restriction and 10 years Probation.

James H. Armstrong, M.D.

(Tempe—Family Medicine)

Arizona License No. 24923

Accepted Consent Agreement for Surrender of License.

Hara P. Misra, M.D.

(Scottsdale—General Surgery/Vascular Surgery)

Arizona License No. 14933

Accepted Consent Agreement for a Decree of Censure and 10 years Probation.

Sudhir Goel, M.D.

(Internal Medicine)

Arizona License No. 27103

Accepted Consent Agreement for Surrender of License.

William N. Foxley, M.D.

(Visalia, CA—OB-GYN)

Arizona License No. 17023

Accepted Consent Agreement for Surrender of License.

(Continued on page 7)

Recent AMB Actions and Orders (continued)

(Continued from page 6)

Robert S. Charlap, M.D.

(Carlsbad, CA—General Practice)

Arizona License No. 31256

Accepted Consent Agreement for Surrender of License.

William M. Cochran, M.D.

(Tucson—Anesthesiology/Pediatrics)

Arizona License No. 15469

Ordered Decree of Censure, 10 years Probation and 10 year Practice Restriction.

Ronald F. Hilding, M.D.

(Phoenix—Psychiatry)

Arizona License No. 6043

Accepted ALJ's Recommended Order for Revocation.

Dwight C. Lundell, M.D.

(Gilbert—Cardiothoracic Surgery)

Arizona License No. 6960

Accepted ALJ's Recommended Order for Revocation.

Bruce J. Bryan, M.D.

(Pinetop—General Surgery)

Arizona License No. 20232

Modified ALJ's Recommended Order to indefinitely Suspend license until Board terms are met; issued Letter of Reprimand and 2 years Probation to start upon reinstatement of license.

David I. Plumb, M.D.

(Family Medicine)

Arizona License No. 37523

Ordered Practice Limitation.

Robert M. Elliott, M.D.

(Costa Mesa, CA—Dermatology)

Arizona License No. 20769

Accepted Consent Agreement for Surrender of license.

Mohammad Z. Qureshi, M.D.

(Tucson—Anesthesiology/Pain Management)

Arizona License No. 8269

Accepted Consent Agreement for Probation and Practice Restriction.

Edwin D. Stump, M.D.

(Tempe—Emergency Medicine)

Arizona License No. 33601

Accepted Consent Agreement for Surrender of License.

Duan C. Copeland, M.D.

(Lakeside—Urology)

Arizona License No. 35699

Approved an Interim Consent Agreement for a Practice Restriction.

Ilangovan Govindarajan, M.D.

(Kingman—Internal Medicine)

Arizona License No. 25797

Approved Interim Consent Agreement for a Practice Restriction and Psychosexual Evaluation.

Alexander Villares, M.D.

(Phoenix—General Surgery)

Arizona License No. 32704

Ordered Letter of Reprimand with 5 years Probation.

AMB Stats

At its two-day April 2008 meeting, the Arizona Medical Board:

- Dismissed 4 cases.
- Upheld 8 ED Dismissals.
- Issued 27 Advisory Letters.
- Ordered 7 Letters of Reprimand.
- Ordered 2 Decrees of Censure.
- Accepted 2 Surrenders of License.
- Invited 3 physicians for Formal Interviews.

At its two-day June 2008 meeting, the Arizona Medical Board:

- Dismissed 6 cases.
- Upheld 28 ED Dismissals.
- Issued 27 Advisory Letters.
- Ordered 13 Letters of Reprimand.
- Ordered 3 Decrees of Censure.
- Accepted 2 Surrenders of License.
- Invited 1 physician for Formal Interview.

At its two-day August 2008 meeting, the Arizona Medical Board:

- Dismissed 7 cases.
- Upheld 18 ED Dismissals
- Issued 35 Advisory Letters

(Continued on page 8)

Reasons for Medical Board Actions

Knowing why physicians have come to the attention of the Arizona Medical Board may be helpful information to other licensees.

The Board ordered **Decrees of Censure** for:

- Failing to appropriately diagnose and treat diabetes and pertussis in a patient, inappropriately diagnosing two patients with diabetes, documenting that a glucometer was medically necessary for a patient who did not have diabetes, inappropriately prescribing Biaxin for a possible urinary tract infection, failing to properly identify a patient prior to discussing a medical diagnosis, failing to notify a patient regarding an abnormal x-ray result, failing to provide complete pap smear results upon patient's request in a timely manner, inappropriate billing, failing to perform and order appropriate laboratory testing for amenorrhea, failing to obtain baseline height and weight in a child with a nutritional deficiency and failing to maintain adequate medical records.

- Knowingly making a fraudulent statement regarding credentials on a patient consent form signed prior to surgery.

- Prescribing without performing examinations on four female patients, failing to coordinate care and communicate with another treating physician of one patient, failing to consider the possibility that the chronic Fioricet prescribed to a patient may have been causing analgesic rebound headache and failing to maintain adequate medical records.

- Failing to obtain an arterial blood gas to assess respiratory status and to determine whether the patient was retaining carbon dioxide, failing repeatedly to take appropriate steps to monitor and recognize an adverse patient response to medications, and continuing to administer medications inappropriately after the patient's adverse response occurred, failing to provide continual care while the patient was still in the emergency department but technically admitted to the hospital, and failing to maintain adequate medical records.

- Knowingly making a fraudulent statement regarding his credentials on a patient consent form prior to surgery.

- Failing to properly assess a patient before and after surgery and performing wrong level spine surgery.

- Failing to conduct an adequate preoperative evaluation, including a consultation with a gynecological oncologist, that compromised the patient's initial surgical procedure and inadequate medical records.

- Violating a Board Order.

- Overprescribing acetaminophen without adequate rationale or appropriate monitoring, prescribing opioid and multiple psychoactive medications in an elderly patient resulting in medication-induced hypersomnolence, and violating a Board Order.

The Board ordered **Letters of Reprimand** for:

- Failing to maintain and retain adequate medical records.

- Failing to continue hospitalization for a patient with a worsening chest x-ray following blunt thoracic trauma and inadequate medical records.

- Failing to disclose truthful information on another state's licensing application.

- Placing a suture through half of the sciatic nerve.

- Failing to interpret PSA results and recommend urological consultation in the face of elevated results and failing to perform a rectal exam to further evaluate the elevated PSA or indicate that a urologist would soon do a rectal exam.

- Failing to adequately document medical decision-making or informed consent for a complex patient.

- Failing to obtain the pertinent laboratory tests for a child presenting with recurrent infections and failing to refer to a specialist for further evaluation.

- Prescribing a controlled substance to an immediate family member.

- Failing to perform a neurological exam and for inadequate medical records.

- Inadequate medical records and for failure to order appropriate baseline and monitoring laboratory and EKG testing when prescribing Lithium and Desipramine.

- Failing to supervise a physician assistant and for inadequate medical records.

- Failing to consider other conditions and conduct appropriate tests when evaluating a patient with multiple

Recent Medical Board Actions and Orders

(Continued from page 7)

- Ordered 15 Letters of Reprimand.
- Ordered 4 Decrees of Censure.
- Accepted 2 Surrenders of License.
- Revoked 2 Licenses.
- Dismissed 8 cases.
- Upheld 11 ED Dismissals.
- Issued 29 Advisory Letters.
- Ordered 12 Letters of Reprimand.
- Accepted 2 Surrenders of License.
- Revoked 2 Licenses.
- Invited 1 for Formal Interview.

At its two-day October 2008 meeting, the Arizona Medical Board:

Reasons for Medical Board Actions (continued)

cavitary lung lesions.

- Failing to ensure that enough clinical information and enough images to address the clinical question had been received and failing to accurately interpret the images provided for two patients.

- Failing to fully dilate a patient's pupils prior to a retinal examination.

- Failing to use properly accredited technicians in performing laser treatment.

- Failing to refer the patient to a retinal specialist in a timely manner and inadequate medical records.

- Inappropriate billing that is not supported by the documentation.

- Failing to properly supervise a nurse midwife, failing to counsel a patient regarding her Rh status and need for future treatment, and inadequate medical records.

- Failing to document notification of changes to the treatment plan to the minor patient's mother.

- Failing to rule out infection prior to prescribing steroids and failing to timely recognize and treat a patient's mesh infection with antibiotics for a sufficient duration.

- Failing to fully evaluate a patient's anemia, failing to include ineffective erythropoiesis as part of the differential diagnosis for macrocytic anemia that required a bone marrow aspiration, and failing to consider ecthyma gangrenosum as a possible diagnosis of skin lesions.

- Failing to perform an adequate neurologic examination and for administrating an abdominal CT scan with contrast to a patient with a known allergy to contrast dye.

- Failing to personally evaluate a patient despite being notified twice by nursing staff that the patient was not doing well and failing to follow up on abnormal CT scan results that the physician ordered.

- Failing to be readily available and respond to hospital staff in a timely manner and failing to maintain adequate records.

- Failing to perform a post-operative vaginal examination on a patient with continued symptoms and complaints of pain and failing to maintain adequate records.

- Failing to timely see two patients with small bowel obstructions and documenting a physical examination that was not performed.

- Providing high-dosed IV narcotics for an acute gout attack, failing to respond to adverse signs of medication, and inadequate medical records.

- Habitual intemperance, using controlled substances not prescribed by another physician, prescribing controlled substances to an immediate family member, and prescribing medication for an extended period of time without conducting a physical examination.

- Failing to recognize acute renal failure and the need for urgent urological evaluation and inadequate medical records.

- Action taken by another state for quality of care issues.

- Photographing and viewing a patient's penile tattoo.

- Improper prescribing, inadequate examination and evaluation of the patient, prescribing in excess of findings reported and failing to recognize or deal with evidence of narcotics abuse on several occasions.

- Treating the physician's own grandchildren for several years without documenting his relationship in the records and actively seeking alternative care for the grandchildren and failing to maintain adequate medical records.

- Transecting a nerve during surgery, failing to diagnose and treat the complication in a timely manner and failing to perform a motor neurologic examination during post-operative follow up.

- Failing to properly evaluate a patient with persistent weight loss, including an oral cavity examination, and failing to obtain a surgical consultation for a patient with new bilateral pneumothoraces, chest pain and hypoxia after a procedure.

- Failing to order prothrombin line, an internation normalized ration and head CT scan for a patient on Coumadin involvined in a motor vehicle accident with a forehead abrasion.

- Failing to diagnose a vascular injury or consult the vascular surgeon about a patient's vascular injury in a timely manner despite being notified by nursing staff about a numb leg with a cold foot.

- Failing to provide adequate post-operative patient care, failing to adequately supervise a physician assistant, failing to timely diagnose and properly treat an operative complication and improper billing.

- Failing to appropriately manage a high risk pregnancy by failing to timely refer a diabetic patient to specialized care in the presence of macrosomia and fetal intolerance of labor.

- Altering medical records, falsifying medical records sent to the Board, failing to order a timely follow up Dilantin level after a dosage change, failing to timely address abnormal lab review in the records and inadequate medical records.

- Failing to review and address diagnostic studies suggesting a malignant lesion and for failing to report the results to the patient for over one year.

- Performing wrong level surgery and for failure to maintain adequate medical records.

- Delay in consideration of, evaluation for, and treatment of the emergent life-threatening causes of hypotension and for failure to maintain adequate medical records.

- Failing to properly supervise a physician assistant.

- Removing the incorrect testicle while performing an orchiectomy.

- Using a blind Veress needle insuffla-

(Continued on page 10)

Reasons for Medical Board Actions (continued)

(Continued from page 9)

tion technique and blind supraumbilical trocar puncture for attempted laparoscopic common bile duct exploration in a patient who is 21 weeks pregnant.

- Prescribing a controlled substance without first conducting an adequate history and physical examination, signing a predated prescription, failing to act upon several red flags indicative of drug-seeking behavior, and failing to maintain adequate medical records.

- Failing to personally evaluate a patient with pre-eclampsia.

- Failing to release records to a patient upon written authorization in a timely manner, inappropriately including information regarding the treatment of family members in another patient's chart, inadequate medical records, and failing to properly evaluate and document patient examinations during the initial and follow up visits.

The Arizona Medical Board issued non-disciplinary **Advisory Letters** for:

- Failing to maintain and retain adequate medical records.

- Failing to continue hospitalization for a patient with a worsening chest x-ray following blunt thoracic trauma and inadequate medical records.

- Failing to disclose truthful information on another state's licensing application.

- Placing a suture through half of the sciatic nerve.

- Failing to interpret PSA results and recommend urological consultation in the face of elevated results and failing to perform a rectal exam to further evaluate the elevated PSA or indicate that a urologist would soon do a rectal exam.

- Failing to adequately document medical decision-making or informed consent for a complex patient.

- Failing to obtain the pertinent laboratory tests for a child presenting with recurrent infections and failing to refer to a specialist for further evaluation.

- Prescribing a controlled substance to an immediate family member.

- Failing to perform a neurological exam and for inadequate medical records.

- Inadequate medical records and for failure to order appropriate baseline and monitoring laboratory and EKG testing when prescribing Lithium and Desipramine.

- Failing to supervise a physician assistant and for inadequate medical records.

- Failing to consider other conditions and conduct appropriate tests when evaluating a patient with multiple cavitary lung lesions.

- Failing to ensure that enough clinical information and enough images to address the clinical question had been received and failing to accurately interpret the images provided for two patients.

- Failing to fully dilate a patient's pupils prior to a retinal examination.

- Failing to use properly accredited technicians in performing laser treatment.

- Failing to refer the patient to a retinal specialist in a timely manner and inadequate medical records.

- Inappropriate billing that is not supported by the documentation.

- Failing to properly supervise a nurse midwife, failing to counsel a patient regarding her Rh status and need for future treatment, and inadequate medical records.

- Failing to document notification of changes to the treatment plan to the minor patient's mother.

- Failing to rule out infection prior to prescribing steroids and failing to timely recognize and treat a patient's mesh infection with antibiotics for a sufficient duration.

- Failing to perform an adequate focused examination with respect to the patient's presenting symptoms.

- Failing to aggressively treat a positive culture of staph aureus and to provide antibiotic coverage.

- Failing to follow up on lab tests and evaluate a patient with known congenital heart disease, pneumonia and anemia for possible endocarditis.

- Failing to obtain blood and urine cultures in a 14-month-old child with fever and a history of congenital heart disease.

- Failing to fully investigate endocarditis diagnosis in a patient with a congenital heart defect, abnormal labs and pneumonia.

- Failing to identify fractures on x-ray.

- Failing to communicate significant findings directly to a referring physician regarding an abnormal x-ray report.

- Failing to conduct further workup on a symptomatic patient with significant cardiac past medical history.

- Failing to obtain proper lab and examination prior to treating with testosterone and failing to discuss the risks and benefits of testosterone therapy with the patient.

- Failing to perform a visual inspection of the colon at the time of surgical resection.

- Failing to adequately communicate the physician's transfer of practice to a patient and covering colleagues, failing to completely fill out the assisted living facility form with medication dosages prior to admittance, and failing to provide current contact information with the Board.

- Failing to identify portal venous gas and findings consistent with mesenteric ischemia on an abdominal CT scan.

- Inappropriately performing a hip arthroplasty resulting in a sustained permanent nerve injury.

- Failing to obtain a patient's blood type and Rh factor prior to the admission of Rhogam.

- Failing to identify a second nodule

(Continued on page 11)

Reasons for Medical Board Actions (continued)

(Continued from page 10)

on x-ray.

- Failing to completely assess a patient with severe aches, vomiting, low blood pressure, and rapid pulse, making a diagnosis of bronchitis that was not consistent with presenting complaints and findings, and failing to adequately supervise office staff.

- Failing to communicate the urgent need for a consultation directly to the surgeon.

- Failing to promptly refer a patient to a retinal specialist following complicated cataract surgery where nuclear material was retained in the eye.

- Failing to monitor a patient's fluid status, failing to restart Lasix when it was indicated and failing to follow up on an abnormal EKG.

- Making a false statement to the medical executive committee on behalf of another physician.

- Failing to appropriately diagnose a lesion resulting in an unnecessary mastectomy.

- Inappropriate prescribing and monitoring of testosterone replacement and for inadequate medical records.

- Failing as a medical director to have effective and written protocols for timely communication regarding pathology report results in place and for inadequate recordkeeping.

- Failing to properly evaluate new onset hypertension, failing to follow up on elevated creatinine, and inadequate medical records.

- Failing to consider a diagnosis of a transient ischemic episode and failing to start the patient on aspirin/ Aggrenox.

- Failing to recognize that a venous Doppler instead of an arterial Doppler was ordered and completed on a patient that led to a delayed intervention on an ischemic limb and for inadequate documentation.

- Failing to document and provide written notification of termination of care, and failing to maintain adequate medical records.

- Failing to close a 10mm fascial layer trocar site.

- Failing to diagnose the patient's condition, using IPL in the treatment of melasma and inadequate medical records.

- Failing to perform a neurological examination and completely assess the patient's complaints, failing to reassess a patient when the patient's condition deteriorated, and inadequate medical records.

- Performing a partial posterior labioplasty instead of a bilateral labioplasty and inadequate medical records.

- Failing to retain medical records as required by statute.

- Failing to provide adequate termination of care.

- Injecting an excessive amount of local anesthetic for a minor biopsy procedure.

- Failing to timely evaluate changes in a patient's neurologic status by failing to personally perform a complete neurologic examination.

- Chaning Lasix and potassium dosages without indication or discussion with the patient and inadequate medical records.

- Failing to obtain and act upon abdominal CT scan findings, specifically free intraperitoneal air.

- Failing to review the patient's response to nitroglycerin, the abnormal EKG, cancelling the cardiology consultation and inadequate medical records.

- Failing to identify a hip fracture on the patient's initial MRI.

- Failing to perform a mathematically accurate conversion of Dilaudid and Fentanyl to intravenous methadone.

- Failing to discuss ultrasound findings with a patient.

- Signing a blank, undated prescription and providing it to a colleague.

- Inadequate treatment of hyponatremia.

- Failing to supervise a physician assistant.

- Failing to properly follow up.

- Failing to establish an appropriate doctor/patient relationship prior to furnishing samples of prescription medication and failing to maintain adequate medical records.

- Failing to identify and report the finding of an epidural abscess compressing the cervical spinal cord.

- Not being available in a timely fashion to evaluate a post-operative patient with potential complications.

- Incomplete removal of a submandibular gland.

- Failing to follow up a vaginal culture for Group B Strep.

- Failing to detect a posterior left temporal AVM on an MRI.

- Failing to recognize that a PDA in a term Trisomy 21 infant is unlikely to close spontaneously and for failing to require that the cardiology consultation that had been previously ordered actually be accomplished prior to or following discharge.

- Failing to update a physician's address and phone number with the Board and for failing to have accurate information on his prescription pads.

- Recommending sun exposure for a patient's damaged skin following IPL and for inadequate medical records.

- Failing to approve inpatient status for a modified radical mastectomy resulting in cancelling of the surgery and delay of appropriate treatment.

- Failing to directly communicate critical CT scan results to the attending hospitalist.

- Failing to document a physical examination, for initiating Armour Thyroid on a patient with normal thyroid function tests, and by continuing Armour Thyroid in the face of a suppressed TSH and normal thyroid function levels.

Arizona Medical Board and Arizona Regulatory Board of Physician Assistants

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The Arizona Medical Board is committed to serving the public through the honest, fair, and judicious licensing and regulation of allopathic physicians (MDs). As it has in the past, the Arizona Medical Board will continue to gain public respect and trust by focusing on the issues that will shape positive healthcare environments.

As the utilization of physician extenders, such as physician assistants, continually increases, the Arizona Regulatory Board of Physician Assistants stays in touch with community needs and implements health care policy reforms to protect the public and provide guidance to its licensees. Within the last few years, the Board has systematically revised its laws and rules to stay abreast of healthcare trends.